SUPREME COURT OF APPEALS OF WEST VIRGINIA

MATTHEW WYSONG,
by his mother, Mary L. Ramsey,

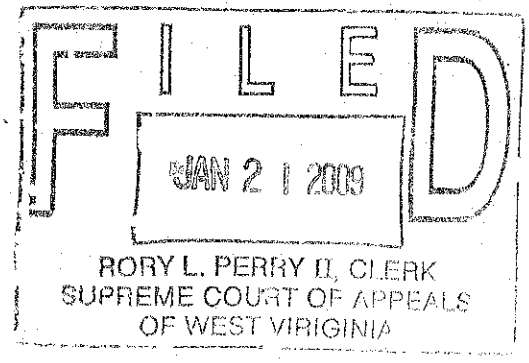
Petitioner below, Appellee,

vs.

Supreme Court No. 34594

MARTHA WALKER, in her official capacity as Secretary of the West Virginia Department of Health and Human Resources; and RAY BURL WOODS, in his capacity as State Hearing Officer for the West Virginia Department of Health and Human Resources,

Respondents below, Appellants.



REPLY BRIEF OF APPELLEE MATTHEW WYSONG

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Respondents below, Appellants.

BRIEF OF APPELLEE MATTHEW WYSONG

I. Additions to Statement of the Case

Petitioner Matthew Wysong, now age 25, was born one month premature, on March 15, 1983. BOR Hrg. Ex. 6, p. 1. At eight months of age he had his first seizure. BOR Hrg. Ex. 7, p. 2. He had no seizures from age 3½ until age 16 or 17, when he began having some 60 seizures a day. BOR Hrg. Ex. 7, p. 2. He has impaired social abilities and difficulties with attention and concentration. BOR Hrg. Ex. 7, p. 2. He was hospitalized for an attempted suicide in September 2001. BOR Hrg. Ex. 7, p.2. He had frontal lobe surgery to address the extreme epileptic seizures issues in September 2004 (at age 21), with follow-up surgeries in October 2004 and August 2005. BOR Hrg. Ex. 7, p.2 (from the "Comprehensive Psychological Evaluation" report of Sandi Kiser-Griffith, licensed psychologist, dated 03-09-06).

In July 2003 Matthew Wysong was evaluated by a therapist and diagnosed with ADHD, Personality Disorder NOS ["Not Otherwise Specified"], and Borderline Intellectual Functioning. BOR Hrg. Ex. 7, p. 2. Three months later, in October 2003 Matthew Wysong was evaluated

again, and diagnosed with Pervasive Developmental Disorder NOS,[1] and Cerebral Palsy and Epilepsy. BOR Hrg. Ex. 7, p. 3.

In the March 2006 Psychological Assessment required as part of the application process for the MRDD Waiver Program Matthew Wysong was evaluated again.[2] This assessment was conducted after the several frontal lobe brain surgeries. In the March 2006 assessment Matthew was diagnosed with "Cognitive Disorder NOS," and Cerebral Palsy, Epilepsy, and "History of Surgery for Left Frontal Lobe Removal." BOR Hrg. Ex. 7, p.8.[3]

Matthew Wysong has Borderline Intellectual Functioning. BOR Hrg. Ex. 7, p. 5.

The assessing psychologist testified that Matthew Wysong is in the average range of

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[1] The assessing psychologist testified that Pervasive Developmental Disability "typically is kind of classified as they have some of the characteristic of autism or autistic disorder, but they don't meet the full criteria for autistic disorder." 08-21-07 Tr. at 11. *See also* Section 299.80, *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) "Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism).

[2] This assessment was performed by licensed psychologist Sandi Kiser-Griffith. At the time of hearing she held a Master's Degree in Clinical Psychology, and had completed all requirements for a doctorate in psychology. 08-21-07 Tr. at 7. She practices as a full-time psychologist. Previously she had been an area director for an agency operating "ICF group homes" (meaning "intermediate care facilities for the mentally retarded"). 08-21-07 Tr. at 8. She estimated she has performed hundreds of assessments for MRDD Medicaid Waiver Program eligibility, 08-21-07 Tr. at 8; and has used the "Adaptive Behavior Scale" assessment instrument an estimated 3,000 times over her years of practice. 08-21-07 Tr. at 40.

[3] At page 9 of their Brief, Appellants state that licensed psychologist Sandi Kiser-Griffith testified that Matthew Wysong had a "personality disorder, not otherwise specified ("PD/NOS"). The transcript citation apparently is to page 34 of the transcript of the Aug 1, 2007 hearing [hereafter cited as "08-21-07 Tr. at 34"], but there is no testimony at that page discussing Matthew Wysong's types of disorders. More importantly, psychologist Kiser-Griffith never stated at any point in her testimony that Matthew Wysong has a "personality" disorder. Instead, she testified that Matthew Wysong has a "cognitive disorder not otherwise specified." 8-21-07 Tr. at 9. *See also* Axis I of Ms. Kiser-Griffith's "Diagnostic Impression" set forth in her Comprehensive Psychological Evaluation dated 03/09/06, BOR Hrg. Exh. 7 at p. 6, which identifies Cognitive Disorder, NOS. Kiser-Griffith explained that earlier in his life Mr. Wysong had been diagnosed with "pervasive developmental disorder - not otherwise specified." 8-21-07 Tr. at 10-11. Later he had frontal lobe surgery to remediate seizures, which caused its own effects. Considering all of these factors, the assessing psychologist described Matthew with the more generic condition of "cognitive disorder - not otherwise specified." 08-21-07 Tr. at 10-11.

abilities compared to people *with mental retardation*. 8-21-08 Tr. at 19. On cross-examination by the DHHR counsel, psychologist Kiser-Griffith testified that Matthew Wysong has a "deficit"[4] in every one of the six "major life areas" defined by the eligibility policy.[5] 08-21-07 Tr. at 33-34. She testified that Matthew's "age equivalent score" in the major life area of "Independent Functioning," indicated abilities equivalent to a person in the general population of age 4 years 3 months. 08-21-07 Tr. at 43-44.[6] The psychologist also testified that she could not separate out the effects of the frontal lobe removal surgery specifically from the effects of the other conditions of Cerebral Palsy, Epilepsy, and Cognitive Disorder (which prior to surgery had been diagnosed as Pervasive Developmental Disability). 08-21-07 Tr. at 12.

II. Response to Assignment of Error

The Circuit Court properly sought to determine the requirements of law and regulation to demonstrate eligibility for the MRDD Medicaid Waiver Program. Where the words of the regulation written by the Appellants were vague and undefined, the Court sought to interpret meaning from underlying federal statutory usage. The Circuit Court then conducted "an independent review of both law and fact, as justice may require" pursuant to Atkins v. Gatson, 218 W.Va. 332, 624 S.E.2d 769 (2005); Harrison v. Ginsberg, 169 W.Va. 162, 286 S.E.2d 276

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[4] "Deficit" is the word used by DHHR counsel in the questions asked. This is apparent short-hand for the lengthier technical term used in the program regulations, which require "substantially limited functioning" in three or more "major life areas." BOR Hrg. Ex. 12, hearing of 05-31-07.

[5] The six "major life areas" are Self-Care, Receptive or Expressive Language, Learning, Mobility, Self-Direction, and Capacity for Independent Living. BOR Hrg. Ex. 12, hearing of 05-31-07.

[6] The score sheet of Matthew's "Adaptive Behavior Scale" assessment administered by Ms. Kiser-Griffith on 03-09-2006 lists an "age equivalent" expression of his abilities across a range of ten "domains" of behaviors. They range from less than age 3 years 0 months for Self-Direction to a maximum of age 10 years 3 months in the domain of "Numbers & Time." His age equivalent comparison was listed at 5 years 6 months or lower in 7 of the ten domains. This for an individual with a chronological age of 22 years 11 months at the time of assessment. BOR Hrg. Ex. 9, page 1.

(1982).

III. Medicaid Law

Appellee believes it is useful to review the underlying federal and state law defining the Mentally Retardation/Developmental Disability Medicaid Waiver Program, before discussing the decision of the Court below. Medicaid generally is an enormously complex area of law, which other courts have characterized as "unintelligible to the uninitiated,"[7] and the regulatory equivalent of the "serbonian bog."[8]

A. General Statutory Framework

The Medicaid program, established by Title XIX of the Social Security Act, 42 U.S.C. § 1396, et seq., is a cooperative federal-state program to enable the states to furnish medical assistance to individuals who are unable to meet the costs of necessary medical services. Costs of the program are shared by the federal and state governments, with the federal government contributing approximately 74% of the costs of services in West Virginia.

A state is not obligated to participate in the Medicaid program. If the state chooses to participate, however, it must operate its program in compliance with federal statutory and regulatory requirements, 42 U.S.C. § 1396(a). West Virginia has chosen to participate in the Medicaid Program.

Medicaid contains certain core-services that are mandatory for any state program. Beyond those mandatory services, states may also choose to cover any of a range of federally recognized services for which federal reimbursement will be available. One of the optional services is intermediate care level services for the mentally retarded and/or developmentally disabled (ICF/MR).

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[7] Friedman v. Berger, 547 F.2d 724, 727 n.7 (2nd Cir. 1976) (Friendly, J.), *cert denied*, 430 U.S. 984, 52 L. Ed. 2d 378, 97 S. Ct. 1681 (1977).

[8] Cherry v. Magnant, 832 F. Supp. 1271 (S.D. IN. 1993).

Once a state chooses to provide an optional Medicaid service, it must comply with all federal requirements for that service.

B. The ICF/MR Medicaid Option

The "Intermediate Care Facility/Mentally Retarded (ICF/MR) Program is an optional Medicaid service authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d(a)(15). ICF/MRs provide residential, health, and rehabilitative services for individuals with mental retardation, developmental disabilities, or related conditions. West Virginia has chosen to include ICF/MR services in its Medicaid state plan.

An ICF/MR is defined as:

[A]n institution for the mentally retarded *or persons with related conditions* if:

> (1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;
> (2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under the subchapter is receiving active treatment under such program . . . .

42 U.S.C. § 1396d(d) [emphasis added].

"Persons with a related condition" to mental retardation is defined as follows:

> Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:
> (a) It is attributable to --
> (1) Cerebral palsy or epilepsy; or
> (2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition *results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons*, and *requires treatment or services similar to those required for these persons.*
> (b) It is manifested before the person reaches age 22.
> (c) It is likely to continue indefinitely.
> (d) It results in substantial functional limitations in three or more of the following areas of major life activity:
> (1) Self-care.
> (2) Understanding and use of language.
> (3) Learning.
> (4) Mobility.
> (5) Self-direction.
> (6) Capacity for independent living.

42 C.F.R. 435.1010 [emphasis added].

C. The Home and Community Based Waiver Program

The Home and Community-Based Waiver program (Waiver program) was adopted by Congress in order to allow individuals who would otherwise require care in a nursing home or ICF/MR to receive needed services in their own homes and in home-like settings. 42 U.S.C. §1396n. See Senate Report No. 97-139 and House Conference Report No. 97-208, 1981 U.S. Code Cong. & Admin. News 396. The regulations state that "section 1915(c) of the Act [42 U.S.C. 1396n] permits states to offer, under a waiver of statutory requirements, an array of home and community based services that an individual needs to avoid institutionalization." 42 C.F.R. § 441.300. The requirements that are waived allow (among other aspects) persons who would not otherwise be eligible under ordinary Medicaid rules to be covered; and services that would not otherwise be covered under ordinary Medicaid rules to be provided.

The West Virginia MR/DD Home and Community-Based Waiver Program provides funding for community supports to individuals with mental retardation/developmental disabilities "or a related condition which constitutes a severe and chronic disability" in lieu of services in an Intermediate Care Facility (ICF).

DHHR policy states that a "related condition" may include "any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons." BOR Hrg. Ex. 12 at page 1.[9]

D. Medical Eligibility Criteria

The DHHR policy defining the eligibility criteria for the MRDD Medicaid Waiver Program

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[9] The version of DHHR regulation introduced at the hearing was in effect at the time the Wysong application was considered, and thus is the law applying to this case. That version was later replaced with a re-numbered version which would be cited as Section 513.3.1 at page 14. The wording was not changed. The new version may be found on-line at: http://www.wvdhhr.org/bms/Manuals/Common_Chapters/bms_manuals_Chapter_500_MRDD.pdf

is broken out into four categories: Diagnosis, Functionality, Active Treatment, and Level of Care. BOR Hrg. Ex. 12, page 1-2. As relevant to the present case, the eligibility pieces are as follows:

Diagnosis

* * * [sub-paragraph omitted]

- Must have a related developmental condition, which constitutes a severe and chronic disability with concurrent substantial deficits.
  - Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the MR/DD Waiver Program include, but are not limited to, the following:
    - Any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons
    - Autism
    - Traumatic brain injury
    - Cerebral Palsy
    - Spina Bifida
    - Tuberous Sclerosis
  - Additionally, mental retardation and/or related conditions with associated concurrent adaptive deficits:
    - Were manifested prior to the age of 22, and
    - Are likely to continue indefinitely.

Functionality

- Substantially limited functioning in three or more of the following major life areas: (Substantial limits is defined on standardized measures of adaptive behavior scores three (3) standard deviations below the mean or less than 1 percentile when derived from non MR normative populations or in the average range or equal to or below the seventy fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported by the documentation submitted for review, i.e., the IEP, Occupational Therapy evaluation, narrative descriptions, etc.)
  - Self-care
  - Receptive or expressive language (communication)
  - Learning (functional academics)
  - Mobility
  - Self-direction

-- Capacity for independent living (home living, social skills, employment, health and safety, community use, leisure).

Active Treatment

- Requires and would benefit from continuous active treatment

Level of Care

- To qualify for ICR/MR level of care, evaluations of the applicant must demonstrate:
  - -- A need for intensive instruction, services, assistance, and supervision in order to learn new skills and increase independence in activities of daily living
  - -- A need for the same level of care and services that is provided in an ICR/MR institutional setting.

BOR. Hrg. Ex. 12, pages 1-2.

IV. Argument

A. THE CIRCUIT COURT CORRECTLY CONCLUDED THAT MATTHEW WYSONG'S CONDITION WAS "SEVERE."

Appellants' first argument, set forth at pages 20-25 of their brief, is that the Circuit Court erred in concluding that Wysong's "Cerebral Palsy was "severe." Appellants make two mistakes in this argument. First, Appellants erroneously seek to consider only Matthew Wysong's Cerebral Palsy condition and not his overall condition. Under federal law however, his overall condition should be considered if (1) it is not mental illness, and (2) it "results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons." BOR Hrg. Ex. 12 at page 1. Second, the Circuit Court was entirely within its appropriate judicial function of ascertaining and interpreting the meaning of the legal term "severe" as set forth in the DHHR regulation.

1. "RELATED CONDITION" ELIGIBILITY IS DETERMINED BY HIS FUNCTIONAL LIMITATIONS AND NEEDS FOR SERVICES, NOT BY THE NAME OF ANY PARTICULAR DIAGNOSIS

Section 1396d(a)(15) of the Social Security Act (Act) authorizes optional Medicaid coverage for services in intermediate care facilities (ICFs). Section 1396d(d) of the Act indicates that the term "intermediate care facility services" may include services in a public institution for the mentally retarded or "persons with related conditions" (ICF/MR).

The term "related conditions" is a broad and expansive term which has been used in federal law since the Developmental Disabilities Services and Facilities Construction Act (DDSFCA), Public Law 91-517, enacted on October 30, 1970 [changed to the Developmental Disabilities Assistance and Bill of Rights Act in 1975, (DDABRA)]. Originally, in the 1970 legislation the term was limited to mental retardation or "other neurological conditions." This restriction to "neurological conditions" was broadened in 1975 to cover any conditions closely related to mental retardation by virtue of a similar impairment or a requirement for similar treatment. Public Law 94-103, Developmental Disabilities Assistance and Bill of Rights Act. The definition was amended further in 1978, and changed the focus of the definition from a categorical to a functional one. Public Law 95-602, Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978. The 1978 revised definition included any mental or physical impairment that limits the person's functional ability in certain activities, and no longer included only specific diagnoses that previously had been used to limit the definition to those impairments closely resembling mental retardation.

The current definition, adopted by the federal agency[10] in 1986, explicitly expands the term to include "any other condition, *other than mental illness*" (emphasis added) which "results in impairment of ... adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons." 42 C.F.R. 1010. The clear emphasis is on individuals who have limited adaptive behaviors similar to those of mentally

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[10] The federal agency, a sub-division of the federal Department of Health and Human Services, was then known as the Health Care Financing Agency (HCFA). It is now known as the Center for Medicare and Medicaid Services, or "CMS."

retarded persons, who need services similar to those required by mentally retarded persons, without regard to the nature of the particular condition which causes the behaviors and the service needs. Only "mental illness" conditions are excluded from the potential scope of "related conditions."

Matthew Wysong does have cerebral palsy, which is included in the WV regulation as an example of a "related condition." But this is not all that he suffers. He is diagnosed with Borderline Intellectual Functioning. Matthew Wysong also had a history of severe epileptic seizure disorder, and then had later frontal lobe surgery before the age of 22 to attempt to eliminate or control the seizures. In the end, Matthew Wysong was diagnosed by the assessing psychologist as having "Cognitive Disorder - Not Otherwise Specified." BOR Hrg. Ex. 7, page 3.

Mr. Wysong's limited functioning and his need for services stems from all of these conditions combined. The assessing psychologist testified that she could not separate out the effects of any one of the conditions which in fact act in combination. 08-21-07 Tr. at 12. She could only provide testimony and assessment as to his entire combined limitation of functioning, and to his entire combined needs for services.

The Appellant's attempt in their brief to restrict their analysis only to the effects of the cerebral palsy[11] is a false distinction, contrary to the whole thrust of amendments to the federal statutory and regulatory definitions since 1970. Much of the Appellants' arguments in the remainder of their brief proceed on this attempt to improperly restrict the consideration of Matthew Wysong's eligibility.

2. INTERPRETATION OF THE TERM "SEVERE"

a) THE TERM "SEVERE' IS NOT DEFINED IN WEST VIRGINIA STATUTE OR REGULATION.

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[11] *See, e.g.,* Appellants Brief at 23, focusing on whether Wysong's "cerebral palsy 'resulted in' these areas of limitation...."

Appellants first argument is that the court below erred in concluding that Matthew Wysong's condition was "severe." But Appellants' own brief concedes that the term "severe" is not defined in the State's regulation. Appellants Brief at 18. This concession was unavoidable, as the State's consulting psychologist acknowledged in the administrative hearing that "there's not a definition per se of severity." 05-31-07 Tr. at 15. The State's consulting psychologist also conceded in testimony that while "we have a policy manual that tells you the rules to follow," that policy manual does not have a definition of severity. 05-31-07 Tr. at 15-16. Appellants brief also concedes that the term is not defined in the federal regulation as a component or criterion *separate from* the detailed eligibility elements set forth at 42 C.F.R. 435.1010. Appellants Brief at 17.

More remarkably, in briefing at two court levels DHHR still has not proffered any definition of the term. The agency's brief in the court below did not offer the first shred of a definition or standard for the term "severe" because it did not even discuss the term "severe."[12]

That lack of a definition is repeated in Appellants Brief to this Court. At page 18 of their brief in this Court, Appellants assert that DHHR "uses a functional *approach* in assessing the threshold determination of whether a 'related condition' is 'severe.' " Appellants Brief at 18 [emphasis added.] But no hint is given as to what exactly that functional "approach" might be. There is no definition provided by which a reasonable person might know in advance whether a condition is or is not severe.

From pages 20 to 25, Appellants' Brief lays out its argument that the Circuit Court committed error in finding Matthew Wysong's condition was severe. Appellants Brief states that "the DHHR's *approach* to the determination of 'severe impairment' is similar to the approach

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[12] The DHHR brief to the Circuit Court, in its "Discussion and Points of Authority" section, referred to the phrase "severe, chronic disability" from the regulation *one time*, at page 18. DHHR made no argument in the court below that the word "severe" somehow constituted a separate independent eligibility requirement different from and in addition to the detailed specific elements set forth immediately following this phrase. The argument being asserted in the Supreme Court was not raised in the court below.

used by school systems in Virginia and West Virginia. ... Thus the DHHR's *approach* to a determination of 'severe' is a reasonable standard...." Appellants Brief at 22 [emphasis added]. But one searches in vain for any definition of this "approach," for any elucidation of what elements would demonstrate the presence or absence of the required degree of "severity." Thereafter Appellants Brief piles many individual facts to obscure the utter lack of definition to their use of the word "severe." At bottom, though, there is no standard articulated by which a judgment of "severe" or "not severe" can be measured and reviewed.

The testimony of the Department's psychological witness on this point is equally lacking in identifying any objective criteria by which the requirement of severity would be measured. Set forth in full, her testimony was:

> Documentation submitted to date does not demonstrate does not support that Mr. Wysong's condition is severe as he is ambulatory, expresses himself through language and can perform basic self-care activities. ...
> ... In order to be eligible for our program individual must have a mental retardation or a related condition which is considered to be severe. In this case, Mr. Wysong's condition, which is cerebral palsy, does not meet the criteria or rise to the ***criteria of severity*** that we see in individuals who are eligible for this program or in ICF/MR homes. Like the denial letter says, because he is ambulatory, he has sufficient fine motor ability to take care of most activities. ... let me just say first that by far, most individuals with cerebral palsy would not qualify for our program. It would be for the very most involved ... [sic] the most seriously involved individuals who have cerebral palsy. When I go into ICF/MR homes or when I have reviewed individuals for the Title XIX Waiver Program who meet our eligibility criteria, these are individuals who are typically spastic, quadriplegic. They are not mobile. They reside in wheelchairs. They are unable to transfer from bed to wheelchair to toilet. They, in many cases, are unable to feed themselves. Mobility is severely impacted and oftentimes language is also severely impacted because articulation is very difficult because of the level of their cerebral palsy.
> * * *
> ... I mean the diagnosis is there, but the severity level is not. That's part of the reason for denial. In other words, most people with cerebral palsy would not be eligible for our program and unfortunately ... [sic] well, fortunately really for him, he does not fall in the level of severity.

05-31-07 Tr. at 7-8 [emphasis added]. Nowhere in this monologue does the psychologist

identify the "criteria of severity" against which the various factual statements could be measured. In cross-examination the DHHR psychologist conceded that she was applying a definition of severity "which does not exist in writing." 05-31-07 Tr. at 16.

The focus of the DHHR psychologist repeatedly was to say that Matthew Wysong was not like the people she sees "when I go into ICF/MR homes." 05-31-07 Tr. at 7. But this focus is contradicted by federal DHHS Medicaid Letter Number 97-10, cited in Appellants Brief at pages 3, 16 and 17. That March 1997 letter is titled "Guidelines Regarding What Constitutes an ICF/MR Level of Care Under a Home and Community-Based Services Waiver." It states, in part:

> As the balance of care has subsequently shifted from institutional to home and community-based care, the more severely disabled individuals have tended to remain in institutions. Moreover, because community-based services tend to be more accessible to higher functioning individuals, these consumers have been more inclined to choose community-based long term care services over institutional care. As a result, the profile of individuals receiving home and community-based care may differ from those served in institutions. However, it would be a mistake to conclude that certain high functioning individuals would not require ICF/MR services merely because their functional abilities exceed the levels ordinarily seen in ICFs/MR nowadays. .... It is important to note that Section 1915(c) of the Social Security Act does not require that individuals served under the waiver "resemble" individuals who remain in the institution.

DHHS Health Care Financing Agency, Medicaid Letter 97-10 (March 06, 1997) [emphasis added], attached to DHHR Circuit Court Memorandum as Exhibit A. But in the absence of any written definition, the DHHR psychologist was doing exactly what HCFA Medicaid Letter 97-10 cautioned against.[13]

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[13] The DHHR psychologist repeated this error in a number of contexts. For example, discussing the major life area of "Self Direction" she stated: ""Self Direction for our program means whether or not an individual would choose to live an active lifestyle of just sit and do nothing for hours at a time. An example of that would be if you go into an ICF/MR group home, you would find individuals there with various disabilities who would sit in their favorite chair or on their spot on the couch all day and do nothing all day...." 05-31-07 Tr. at 14. She later conceded DHHR regulation does not set forth this notion of "sit in your chair and do nothing all day." 05-31-07 Tr. at 17.

The federal Medicaid statute requires that a State's Medicaid Plan must "include *reasonable standards* ... for determining eligibility for and the extent of medical assistance under the plan...." 42 USC §1396a(a)(17) [emphasis added]. This requirement is repeated in the West Virginia Code, which sets forth that "Recipients ... shall be entitled to have costs of necessary medical services [covered] ... pursuant to rules, regulations and *standards*.... Such rules, regulations and *standards* shall comply with requirements of applicable federal laws, rules and regulations...." WV Code §9-4-2 [emphasis added].

But the only "standard" the DHHR witness ever articulated was the circular conclusory assertion that Mr. Wysong's condition "does not meet the criteria or rise to the criteria of severity that we see in individuals who are eligible for this program." 05-31-07 Tr. at 8. This testimony was not analysis, and did not set forth any "criteria" by which the conclusion was reached. It simply repeated the conclusion: these needs are not the type of needs for which ICF/MR services are intended. The circularity of the reasoning is apparent when one inserts the question before the answer: "Question - why does Matthew Wysong's condition not meet the criteria for Severe? Answer - because his condition does not meet the criteria for Severe."

A denial based upon criteria which are not stated in policy or regulation is invalid. See Franklin v. Arkansas Dep't of Human Servs., 319 Ark. 782, 894 S.W.2d 584 (1995); and Arkansas Dep't of Human Servs. v. Kistler, 320 Ark. 501, 898 S.W.2d 32 (1995). "A decision can be nothing but arbitrary when it is based upon no discernible standard." Franklin v. Arkansas Dep't of Human Servs., *supra*, (Newbern, concurring).

Yet the State denied Matthew Wysong's application because he did not meet some unknown, unstated, undefined, unbounded requirement.[14] How exactly would any court

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[14] In the experience of undersigned counsel for appellee, the attempt by DHHR in Wysong to create a conceptually independent eligibility criterion of meeting a test of "severe," separate from meeting the numerous detailed elements set forth at 42 C.F.R. 435.1010, is wholly new. The Wysong case was the first time that this counsel, after handling numerous other MRDD Waiver Program cases, had ever encountered this assertion by the State. Since the Wysong hearing, the State has continued to assert this vague undefined element as a basis

"review" this determination? There would seem to be three alternative choices. One option would be to look to other uses of the word "severe" in the federal Social Security Act of which Medicaid is a part, and apply that meaning to the Medicaid MRDD Waiver Program context. A second option would be to conclude that the word "severe" does not form a separate element of eligibility independent of the more detailed elements that follow the general statement. A third option would be to void the State's use of the word "severe" as an arbitrary and capricious denial of benefits based upon an unwritten, unstated, undefined "criterion" that does not exist in the law. These alternatives are discussed below.

b) FIRST OPTION: CONCLUDE THAT THE TERM "SEVERE" HAS MEANING DERIVED FROM ITS USE IN OTHER SOCIAL SECURITY ACT PROGRAMS

The Medicaid program is one of a number of programs within the larger Social Security Act. Title 42 of the US Code, Chapter 7, contains the Social Security Act. Medicaid is Sub-Chapter XIX of the Social Security Act, found at 42 U.S.C. 1396 *et.seq.*

The term "severe" has been used and defined in other programs enacted under the Social Security Act. In particular, it is used as a preliminary screening step in determining eligibility for the twin disability benefits programs of Social Security Disability and Supplemental Security Income.[15] As set forth below, if an applicant's alleged impairment is found at an early step to be not "severe," then a denial is issued without going through the remaining steps of a much more detailed analysis.

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for denial, although no definition has ever been set forth.

[15] These two benefit programs are both based on the core concept of "disability." SSD is an insurance program that pays a monetary benefit to the disabled person, the amount of which is determined by the person's work and earnings history, regardless of any other independent income the disabled person may have. (If he became disabled, Bill Gates would be eligible for a monthly SSD benefit.) The SSI program is a minimum income program, that pays whatever monetary amount is needed in combination with the disabled person's other independent income to bring the disabled individual up to a floor income of $674 per month presently. (Anyone with more than $674/month independent income is not eligible for any SSI benefit payment.)

The Social Security Disability (SSD) program is Sub-Chapter II of the Social Security Act. The Supplemental Security Income (SSI) program is Sub-Chapter XVI of the Social Security Act. Both of these programs, using mirror image definitions and procedures, pay defined monetary benefits to individuals who meet the federal definition of "disability."[16]

The federal regulations elaborate on the general statutory definition with a much more detailed procedure for determining whether an applicant meets the definition of Disability. In particular, those regulations set forth a "five-step sequential evaluation process." 20 C.F.R. 404.1520(a)(4) [for SSD]; 20 C.F.R. 416.920(a)(4) [for SSI]. If at any step a decision of "not disabled" can be made, then the case is decided without proceeding through the subsequent steps. Thus the five-step process is a progressive screening system, designed to weed out the most unqualified cases quickly and easily, before progressing to more detailed and expensive assessment steps later in the process.

The second step in the process is to determine whether the applicant has a "severe medically determinable physical or mental impairment." 20 C.F.R.404.1520(a)(4)(ii) [for SSD]; 20 C.F.R. 416.920(a)(4)(ii) [for SSI]. If the alleged impairment is not "severe" then an adverse decision is rendered. Steps 3, 4 and 5 of the process, which are much more thorough, detailed, time consuming and expensive, are avoided.

Surprisingly, the term "severe" is not defined in the federal statute or regulations. Not surprisingly, this led to much litigation, in both administrative hearings and subsequent judicial appeals, as to the exact meaning of the criterion being applied by SSA. Over time many judicial appeals developed a meaning for the term that fit its use as a screening device in the early stages of assessing a particular case. *See* MacDonald v. Secretary DHHS, 795 F.2d 1118, at 1121-1126 (1st Cir. 1986) for a summary of this history. Eventually, in 1985 the Social Security

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[16] The Social Security Act contains only a general definition of "disability," which is identical for both programs. See 42 U.S.C. 416(i) (for the SSD program); and 42 U.S.C. 1382c(a)(3)(A) (for SSI).

Administration issued Social Security Ruling 85-28 (hereafter "SSR 85-28"), accepting those judicial interpretations and applying them throughout the SSD/SSI Disability Determination process. Under SSR 85-28, a finding of "non-severe" was to be made only where

> "medical evidence establishes only a slight abnormality or combination of slight abnormalities which would have no more than a minimal effect on an individual's ability to work."

Social Security Ruling 85-28.[17]

In the administrative hearing below, all expert witnesses agreed that Matthew Wysong's condition met this standard which would be used in the SSD/SSI five-step sequential evaluation process. The State's consulting psychologist agreed that his condition was "more than just a slight abnormality when compared to the general population;" and that his condition "isn't just minimal." 05-31-07 Tr. at 16. Psychologist Kiser-Griffith, who performed the assessment of Matthew Wysong, testified that he did not have a "slight abnormality" but "a very significant impairment." 08-21-07 Tr. at 15. She agreed that she would "not characterize his limitations as only a minimal effect upon his abilities," and that there is a "significant difference" between "his abilities to perform activities of daily living, and the abilities of the ordinary person in the general population." 08-21-07 Tr. at 15.

The Circuit Court made findings of fact adopting these statements by both the State's consulting psychologist and the assessing psychologist. *See* Findings of Fact 23 and 30. Then the Circuit Court concluded that Mr .Wysong's condition was Severe. *See* Conclusion of Law 3. In reaching that conclusion the Court below applied a meaning of the term "severe" drawn from the term's use in other Social Security Act programs, because the direct MRDD Waiver regulations written by the State supplied no meaning or definition whatsoever.

Just like the federal judicial case law interpretive process described in MacDonald v. Secretary, DHHS, 795 F.2d 1118, at 1121-1126 (1st Cir. 1986), the Court below engaged in

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[17] Available at the Social Security Administration web site at: http://www.ssa.gov/OP_Home/rulings/di/01/SSR85-28-di-01.html

the ordinary judicial task of ascertaining meaning of a word in a legal regulation. It adopted an interpretation carrying the collateral benefit that it would accomplish a "de minimum screening" effect as described in MacDonald v. Secretary, DHHS *supra.* This approach would thus simplify the DHHR evaluation task in some cases in the future. Under this standard, essentially frivolous MRDD Waiver applications that did not present any significant impairment could be denied without engaging in further detailed and expensive review.

c) OPTION TWO: CONCLUDE THAT THE TERM "SEVERE" HAS NO MEANING INDEPENDENT OF THE MORE DETAILED SPECIFIC ELEMENTS WHICH FOLLOW IT

As an alternative, the Circuit Court might have ruled that the term "severe" was defined solely by the four specific sub-sections that followed the generic use of the term in the Waiver Manual at BOR Hrg. Ex. 12. A person with a "severe" condition would be one with a qualifying diagnosis, manifested before age 21, likely to continue indefinitely, that resulted in substantial limitation in three or more major life areas. A person who did not meet all of those elements would not have a "severe" condition. In essence, the more general term "severe" would be supplanted by the more specific definitional elements that follow it. On that interpretation there would be no "de minimus screening" effect, and all future MRDD Waiver program applications would be reviewed for all four elements of the regulatory statement.

d) OPTION THREE: CONCLUDE THAT THE TERM HAS NO MEANING, AND THAT A DENIAL BASED ON A TERM WITHOUT MEANING IS AN ARBITRARY AND CAPRICIOUS DENIAL OF DUE PROCESS

The third possible choice would appear to have been to declare that a denial based on a term that is unwritten and undefined is an inherently arbitrary and capricious exercise of governmental authority. As noted previously, a denial based upon criteria which are not stated in policy or regulation is invalid. See Franklin v. Arkansas Dep't of Human Servs., 319 Ark. 782, 894 S.W.2d 584 (1995); and Arkansas Dep't of Human Servs. v. Kistler, 320 Ark. 501, 898 S.W.2d 32 (1995). "A decision can be nothing but arbitrary when it is based upon no discernible standard." Franklin v. Arkansas Dep't of Human Servs., *supra*, (Newbern,

concurring).

Ultimately, there can be no accountability - judicial, administrative, or political - if we allow a faceless government bureaucrat to say "this person gets benefits; this person doesn't" without setting forth a rule by which the decision is made. It isn't enough to say "you don't qualify because you aren't like the people who do qualify." For this purpose, a definition which doesn't exist in writing, *see* 05-31-07 Tr. at 16, doesn't exist in law.

On this option the Court below might have reversed the portion of the agency's ruling which was based on an alleged lack of a "severe" condition, and considered the remainder of the case on the other elements set forth in the regulations. This choice would have had the same functional effect as the second choice, of simply finding that the generic term was supplanted by the more specific elements that followed it.

B. THE CIRCUIT COURT CORRECTLY CONCLUDED THAT THE LIMITATIONS OF MATTHEW WYSONG'S "RELATED CONDITION" MET THE "SUBSTANTIALLY LIMITED FUNCTIONING" TEST

Virtually the entirety of Appellants argument on this point rests upon their mistaken effort to consider only Mr. Wysong's cerebral palsy, and to exclude his other conditions and limitations. This is contrary to the expansive concept of "related condition," which is defined solely by reference to the types of limitation a person has, and the types of needs a person has. Other than the exclusion of limitations caused by "mental illness," the underlying etiology or name is irrelevant.

The federal history of the expansion of the meaning of "related condition" was set forth earlier, and will not be repeated here. See Appellee's Brief, at pages 9-10 *supra*. In the end, the definition of "related condition" for purposes of eligibility for the MRDD Waiver Program, focuses on two elements:

- the "condition results in impairment of general intellectual functioning or adapative behavior *similar to* that of mentally retarded persons," and

- the condition "requires treatment or services *similar to* those required for" mentally retarded persons.

See 42 C.F.R. 435.1010 [emphases added].

The federal regulation is explicit that a "related condition" may be either "cerebral palsy or epilepsy" (both of which Wysong has), "***or***" ... "[a]ny other condition found to be closely related" because of the person's "limitations" and "required services" are "similar to" those of mentally retarded persons. 42 C.F.R. 435.1010.

Despite this, Appellants Brief alleges as error that the Circuit Court did not find that "Wysong's cerebral palsy 'resulted in' these functional limitations," and that "the Circuit Court's own description of the adaptive deficits it identified shows no nexus between *cerebral palsy* and the deficit." Appellants Brief at 25 [emphasis added].[18]

Appellants argument on this point is erroneous, because the law does not require a showing of such a nexus. Instead, the focus is simply whether the person's "limitations" are similar to those of the mentally retarded, and whether the person's "required services" are similar to those of the mentally retarded.

Matthew Wysong's assessment scores on the "Adaptive Behavior Scale" instrument[19]

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[18] *See also* Appellants Brief at 26, "there is no evidence that Wysong's cerebral palsy 'results in substantial limited functioning' in this life activity;" at 26, "neither Workman nor Ms. Kiser-Griffith testified that Wysong's lack of self-direction results from his cerebral palsy;" and at 27, "there is no evidence that Wysong's lack of self-initiative is the result of his cerebral palsy."

[19] "Adaptive behaviors" are everyday living skills such as walking, talking, getting dressed, going to school, going to work, preparing a meal, cleaning the house, etc. They are skills that a person learns in the process of adapting to his/her surroundings. Since adaptive behaviors are for the most part developmental, it is possible to describe a person's adaptive behavior as an age-equivalent score. An average five-year-old, for example, would be expected to have adaptive behavior similar to that of other five-year-olds.

The purpose of measuring adaptive and maladaptive behavior is usually either for diagnosis or for program planning. Adaptive behavior assessment is also used to determine the type and amount of special assistance that people with disabilities may need. This assistance might be in the form of home-based support services for infants and children and their families, special education and vocational training for young people, and supported work or special living arrangements such as personal care attendants, group homes, or nursing homes for adults. Adaptive behavior assessments are often used in preschool and special education programs for

amply demonstrate that his limitations meet the "substantial limitation" test as defined in the State's regulation. That definition provides two alternative measurements of "substantial limitation," using standardized measures of adaptive behavior scores. One alternative is set forth as "three (3) standard deviations below the mean or less than 1 percentile when derived from non MR normative populations. BOR Hrg. Ex. 12, page 2. The other is "in the average range or equal to or below the seventy fifth (75) percentile when derived from MR normative populations." BOR Hrg. Ex. 12, page 2. Matthew Wysong meets this second standard.

Matthew Wysong's ABS scores are set forth in the assessing psychologist's "Comprehensive Psychological Evaluation." BOR. Hrg. Ex 9. His "raw scores" are compared "with other people with mental retardation." 08-21-07 Tr. at 18. On 7 out of 10 domains in the Section II Subtest, Matthew was assessed at the 75th percentile or lower when compared to the population of individuals with mental retardation.[20] At the time of the assessment he was 22 years 11 months in chronological age. In those seven areas of functioning he was judged age equivalent to children aged 5 years 6 months or younger. Psychologist Kiser-Griffith testified in response to cross examination by the DHHR attorney that Matthew Wysong had substantial limitation in all six "major life areas" listed in the State's regulation. 08-21-07 Tr. at 33-34.

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determining eligibility, for program planning, and for assessing outcomes.

The AAMR Adaptive Behavior Scale 2nd edition (AAMR ABS) was developed by the American Association on Mental Retardation, the oldest professional organization devoted to mental retardation in the United States. Its adaptive behavior scale is available in two forms -- one for School, the other Residential and Community Settings. Both versions assess the manner in which individuals cope with the natural and social demands of their environment.

The information in this footnote was taken from an article on line at http://www.come-over.to/FAS/VinelandCompare.htm

[20] At one point during her cross examination, the assessing psychologist erroneously said that Matthew Wysong did not fall below the 75th percentile from the MR normative population. See 08-21-07 Tr. at 30 and 34. This appears to be an inadvertent error. Her written Comprehensive Psychological Evaluation containing the scores and percentile comparisons speaks for itself, and shows 7 or 10 areas at 75th percentile or lower. BOR Hrg. Ex. 9. She had earlier testified to specific scores that were lower than the 75th percentile, see 08-21-07 Tr. at 18 and 23. Finally, in re-direct examination she testified that Matthew's scores in the area of Independent Functioning were in the 50th percentile quantified against the MR population.

Thus the Circuit Court was following the clear mandate of federal law. An applicant's eligibility is judged by the total functional effects of his limitations, no matter what underlying conditions may cause those limitations.[21]

C. THE CIRCUIT COURT CORRECTLY CONCLUDED THAT MATTHEW WYSONG MET REQUIRED ICF/MR LEVEL OF CARE

1. ACTIVE TREATMENT

The term "active treatment" or "continuous active treatment" is used but is not defined in the MRDD Waiver Program Policy Manual. *See* BOR Hrg. Ex. 12 at page 2. It is defined, however, in the Policy Manual for Medicaid ICF/MR Services, as follows:

> Active Treatment - aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

Definition of "Active Treatment" in Section 511.1, "Definitions" of the ICF/MR Services Policy Manual.[22]

Ms. Sandi Kiser-Griffith, the independent assessing psychologist for Matthew Wysong, testified specifically that Matthew Wysong would benefit from training and services in each of the three major life areas where he has Substantially Limited Functioning. She addressed the training and instruction he would need in the area of Self-Direction, 08-21-07 Tr. at 19-20; in the area of Independent Living, 08-21-07 Tr. at 24; and in the area of Self-Care, 08-21-07 Tr. at 26-27. She pointed out that the "Recommendations" section of her Comprehensive

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[21] Only "mental illness" is excluded from the broad reach of this functional definition. But neither the DHHR psychologist nor the assessing psychologist identified any "mental illness" in Matthew Wysong's condition.

[22] Now re-codified as Section 511.1, and available on-line at: http://www.wvdhhr.org/bms/Manuals/Common_Chapters/bms_manuals_Chapter_500_ICFMR.pdf

Psychological Assessment included a number of specific training activities for Matthew Wysong. 08-21-07 Tr. at 45, referring to BOR Hrg. Ex. 7, pages 6-7. The "Placement" section of that assessment also included the statement that "He will benefit from participation in training programs designed to enhance his abilities in social skill areas, domestic activities, money management and vocational activities. Participation in training programs designed to address his adaptive deficits are recommended." BOR Hrg. Ex. 7, page 7.

When questioned specifically about the definition of Active Treatment, the assessing psychologist Ms. Kiser-Griffith confirmed that Matthew Wysong required Active Treatment:

> Q: If active treament is defined as intensive instruction, services, assistance and supervision - -
> A: Right
> Q: - - did you testify earlier that he needed - -
> A: Yes, he does.
> Q: - - intensive instruction, services, assistance and supervision?
> A: Yes.
> Q: So if that's the definition of active treatment, does he need active treatment?
> A: Yes.

Ex. 21, p. 14-15 (pages 47-48 of transcript of August 1, 2007 hearing).

Ms. Workman, the DHHR psychologist, gave her contrary conclusion that the assessing psychologist's report "has not indicated a need for active treatment on section five of the DD-3." 05-31-07 Tr at. 14. But here also there is simply no definition in DHHR regulations which sets forth any standard by which the DHHR made this judgment. As with the "Severity" issue, the DHHR psychologist refers to many individual facts, to obscure the problem that there simply is no definition or standard against which these facts are being measured.

The full definition of Active Treatment is set forth above. That definition also provides that:

> Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

Section 511.1, "Definitions" of the ICF/MR Services Policy Manual. No one can read the evidence concerning Matthew Wysong and conclude that he is "generally independent" and is "able to function with little supervision." If "generally independent" and "little supervision" is what is *excluded*, then Matthew Wysong surely is *included*.

The assessing psychologist's report and testimony meet all the components of the definition provided in the written regulatory materials. The only thing to the contrary is the DHHR psychologist's conclusory assertion, without benefit of any standard or definition whatsoever, that Matthew Wysong does not require "Active Treatment."

2. ICF/MR LEVEL OF CARE

The MRDD Waiver Program Policy Manual states that an individual must:

> Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) .... An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides 24 hour supervision, training and supports.

BOR Hrg. Ex. 12, page 1. Additionally, the MRDD Waiver Program Policy Manual states that to qualify for ICF/MR level of care evaluations of the individual must demonstrate:

> - A need for intensive instruction, services, assistance and supervision in order to learn new skills and increase independence in activities of daily living
> - A need for the same level of care and services that is provided in an ICF/MR institutional setting.

BOR Hrg. Ex. 12, page 2.

The first prong of this provision seems to require that an individual need 4 types of help (instruction, services, assistance, supervision) for two purposes (learn new skills, increase independence). The assessing psychologist, Ms. Kiser-Griffith, wrote in her report and testified in the hearing to the specific instruction, services, assistance, and supervision that Matthew Wysong requires. See "Recommendations," "Placement" and "Therapy/Counseling" sections of the Comprehensive Psychological Examination, BOR Hrg. Ex. 7 at page 6-7; and her testimony at 08-21-07 Tr. at pages 8-10 and pages 14-15.

The second prong of this provision states that the individual must require the " level of care and services that is provided in an ICF/MR institutional setting." There is no further definition in the MRDD Waiver manual of what this means. The ICF/MR Policy Manual contains the following definition, almost identical to the "Active Treatment" provisions in the MRDD Waiver Manual:

> The applicant requires and would benefit from active treatment. Evaluations of the applicant must demonstrate a need for intensive instruction, services, assistance, and supervision in order to learn new skills and increase independence in activities of daily living.

Section 511.5, ICF/MR Policy Manual. As already discussed with regard to the Active Treatment requirement,[23] the assessing psychologist wrote in her report and testified in the hearing to the specific instruction, services, assistance, and supervision that Matthew Wysong requires. See "Recommendations," "Placement" and "Therapy/Counseling" sections of the Comprehensive Psychological Examination, BOR Hrg. Ex. 7 at page 6-7; and her testimony at 08-21-07 Tr. at pages 8-10 and pages 14-15. Thus, the assessing psychologist's report and her testimony demonstrate that Matthew Wysong in fact meets each sub-element of the definition in the Policy Manuals for ICF/MR level of care.

Appellants Brief correctly quotes the ICF/MR Policy Manual that "an ICF/MR facility provides 24 hour supervision, training and supports." Appellants Brief at 28, quoting BOR Hrg. Ex. 12, page 1. And it is true that *some individuals* in ICF/MR settings do require 24 hour supervision, training and supports. But Appellants then imply that the statement is something more than it is - that it is a requirement that only those needing 24 hour services are eligible. This implication is refuted by the 1997 HCFA Medicaid Letter, which was clear that

> "it would be a mistake to conclude that certain high functioning individuals would not require ICF/MR services merely because their functional abilities exceed the levels ordinarily seen in ICFs/MR nowadays. .... It is important to note that Section

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[23] See text at pages 22 - 24 *supra*

> 1915(c) of the Social Security Act does not require that individuals served under the waiver "resemble" individuals who remain in the institution."

DHHS Health Care Financing Agency, Medicaid Letter 97-10 (March 06, 1997).

As with the Severity issue, and the Active Treatment issue, the DHHR psychologist offered a conclusory assertion that Matthew Wysong did not have needs for the types of services required by mentally retarded people who are in ICF/MR facilities. She recited a string of facts, but failed to connect them to the particular elements of the requirement: "intensive instruction, services, assistance, and supervision in order to learn new skills and increase independence in activities of daily living." Section 511.5, ICF/MR Policy Manual.

D. DEFERENCE TO THE DECISIONS AND PROCEDURES OF THE AGENCY

As reviewed *infra*, every argument in this case rests upon "legal" issues - determination of what legal rules apply; what are the definitions of the applicable terms; and how do those rules apply to the facts. Those legal issues are "questions of law," which a reviewing court may review *de novo*. Syl. Pt. 1, Helton v. REM Community Options, Inc., 218 W.Va. 165, 624 S.E.2d 512 (2005). Such *de novo* review of legal questions is fully within the Circuit Court's authority pursuant to the Writ of Certiorari jurisdiction for appeal of the administrative agency decision in this case. *See* Atkins v. Gatson, 218 W.Va. 332, 624 S.E.2d 769 (2005); Harrison v. Ginsberg, 169 W.Va. 162, 286 S.E.2d 276 (1982).

The Circuit Court did not make one Finding of Fact[24] which reversed or contradicted any Finding of Fact by the "State Hearing Officer" in the administrative decision.[25] This is not a case in which the reviewing court reversed the fact findings of the administrative decision, or took

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[24] The Circuit Court's findings of fact are enumerated as paragraphs 1 through 37 in the Order of April 7, 2008.

[25] The State Hearing Officer's findings of fact are enumerated as paragraphs 1 through 38 of the administrative decision of August 15, 2007. A few of those "findings of fact" would appear to be more accurately characterized as conclusions of law.

new evidence pursuant to the authority of the Writ of Certiorari.[26]

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[26] This Court has indicated in prior cases that, on review of administrative agency decisions pursuant to Writ of Certiorari, the Circuit Court may conduct an "independent review of both law and fact, as justice may require." *See* Atkins v. Gatson, 218 W.Va. 332, 624 S.E.2d 769 (2005); Harrison v. Ginsberg, 169 W.Va. 162, 286 S.E.2d 276 (1982). That review may include the taking of new evidence not submitted to the administrative agency, in appropriate circumstances. *See also*, Frymier-Halloran v. Paige, 193 W.Va. 687, 458 S.E.2d 780 (1995).

That authority and discretion may be particularly appropriate where the administrative agency is wholly exempt from the requirements of the Administrative Procedures Act, and does not choose to adopt even rudimentary processes to obtain public comment and input; and where its administrative hearings lack features common to other agencies which promote rational and logical outcomes. With regard to rules and cases relating to "the receipt of public assistance," DHHR is such an agency.

Public rule making procedures have been hailed by some as "one of the greatest inventions of modern government." K. Davis, Administrative Law Treatise, §1.04-5; *cited at* Neeley, Administrative Law in West Virginia, §4.01 (1982). Alfred Neeley described it as "an efficient means of developing policy ... rather than *ad hoc* adjudication on a case-by-case basis." Neeley, Administrative Law in West Virginia, §4.01 (1982). Procedures for public rule making open the process to alternate views, and promote the quality and rationality of the policy developed. But with regard to "the receipt of public assistance," DHHR has never chosen to establish a required procedure for promulgating its own rules. Thus it deprives itself of the benefit of views and suggestions that others might submit.

When DHHR promulgates rules, it often has failed to file them with the Secretary of State as required by W.Va. Code 29A-1-3(c). Moreover, even when DHHR files its rules it refuses to conform them to the mandatory numbering format required of all agencies. *For more information see* LAWV v. Walker, Supreme Court Docket No. 080630.

With particular regard to conduct of administrative hearings involving public assistance, DHHR has adopted some unusual stances. The hearing officers typically are not attorneys, and instead have been career employees and social workers within DHHR. They may have no education or qualification for evidentiary rules and other legal procedures. The DHHR regulation governing conduct of hearings states that "the Rules of Evidence as applied in civil cases in the circuit courts ... shall be followed." DHHR Common Chapters Manual §710.20.I

But with regard to "oral statements of a person made to another," such hearsay is admissible "only when the person making the statement is present at the hearing and available for cross-examination." DHHR Common Chapters Manual §710.20.H.1. At a stroke, DHHR eliminates most of the Hearsay Rule exceptions contained in Rule 803, where the availability of the declarant is "immaterial", and Rule 804, where the declarant is unavailable. The hearing officer may consider "evidence presented in written form only when the individual preparing the report is present at the hearing for cross-examination." Again, this proviso may eliminate significant Hearsay Rule exceptions under standard evidence law.

The DHHR hearing regulation is available on line at:
http://www.wvdhhr.org/oig/a%20-%20oig%20-%20common%20chapters/common_chapters_manual.htm]

Due to all of these peculiarities, in some cases it may be fully appropriate for the Circuit Court on review to take additional evidence or apply different rules of review, to assure that the claimant in the administrative proceeding has received a full and fair hearing in accord with Due Process of Law.

In the present case, however, the Circuit Court did not take additional evidence and did not contradict the findings of fact of the administrative decision. The "peculiarities" of DHHR

On the issue of "Severity," the Circuit Court's decision rested upon determining the meaning of the word "severe" as used in the State's regulation. The administrative agency's own regulations provided no guidance whatsoever, and Appellants proffered no guidance in their briefing to the Circuit Court. The court below ascribed meaning to the term "severe" equivalent to that term's usage in other Social Security Act programs. On this issue the Circuit Court was reviewing an issue of law *de novo.* The Circuit Court ruling on this point did not rest upon differing fact findings from the proceedings below, and no deference is due to the agency.

On the issue of the "substantially limited functionality" test, the Circuit Court reviewed the agency's erroneous legal interpretation of the term "related condition." Appellants have explicitly argued in their briefing to this Court that Matthew Wysong's application should be denied because the agency should consider only Matthew Wysong's cerebral palsy, and not the overall complex of "limitations" and "service needs" that he displays. The court below reviewed that question of law *de novo*, and applied the correct legal standard that all of Matthew Wysong's limitations should be considered. On this issue the Circuit Court was reviewing an issue of law, and no deference is due to the agency.

On the Level of Care/Active Treatment issue, the Circuit Court merely applied the legal rules and definitions to the facts. The court below did not reverse any finding of fact made by the agency, and did not take any additional evidence. It is the appropriate role of the court to review *de novo* the application of law to fact.

V. CONCLUSION

The decision of the Circuit Court should be affirmed. That court acted fully within its appropriate judicial function of reviewing questions of law *de novo*, while not taking any new

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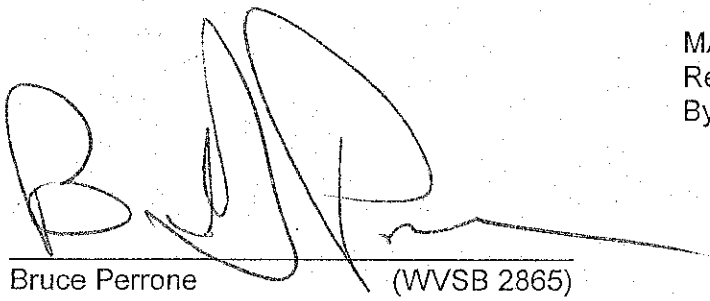
process did not affect the proceedings in the present case. Therefore Appellee would urge this Court to avoid unnecessarily broad pronouncements about the scope of review or judicial deference due to proceedings by this particular administrative agency.

evidence and not making any fact finding in contradiction to the administrative agency. Where the state's regulation was utterly lacking in definition of the term "Severe," the Circuit Court applied an appropriate definition as used in other Social Security Act programs, and concluded that the facts found by the administrative officer met that standard. Where the state applied an improper legal standard to restrict consideration of Matthew Wysong's limitations and needs, the court below appropriately held that all of Matthew's limitations and needs should be considered and that the facts demonstrated that he met the Substantial Limitation test when all aspects were considered. On the Level of Care/Active Treatment issue, the Circuit Court merely applied the legal rules and definitions to the facts as developed below, without taking new evidence or contradicting any finding by the administrative agency.

Respectfully submitted

MATTHEW WYSONG,
Respondent,
By counsel.



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SUPREME COURT OF APPEALS OF WEST VIRGINIA

MATTHEW WYSONG,
by his mother, Mary L. Ramsey,

Petitioner below, Appellee,

vs. Supreme Court No. 34594

MARTHA WALKER, in her official capacity as Secretary of the West Virginia Department of Health and Human Resources; and RAY BURL WOODS, in his capacity as State Hearing Officer for the West Virginia Department of Health and Human Resources,

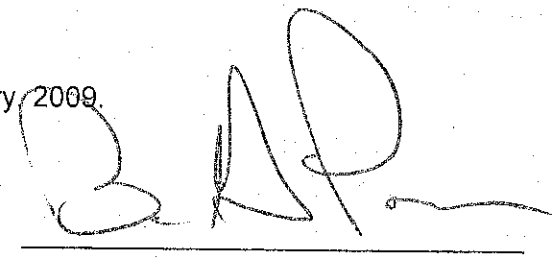
Respondents below, Appellants.

CERTIFICATE OF SERVICE

I hereby certify that I have served a true and accurate copy of the foregoing "Brief of Appellee Matthew Wysong" by depositing a true copy in the United States Mail, first class postage pre-paid, to the following persons, addressed as follows:

Mary McQuain
Assistant Attorney General
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

All of which was done this this 19th day of January, 2009.



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